Euthanasia and law in Europe

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Introduction

1.1 This Book and its Readers

This book is about euthanasia and other medical behaviour that potentially shortens life (MBPSL), and about their legal regulation. The primary focus will be on the Netherlands and Belgium because presently they are the only countries in the world in which euthanasia, under specific circumstances, is legally permissible.[1] In the Netherlands, considerable attention has been paid over a number of years to the problem of regulating it. Information has been systematically collected concerning actual practice. Legal and open euthanasia practice in Belgium is of very recent date (2002) and legalisation took place without the decades of debate and experimentation that preceded legislation in the Netherlands, so that legal, ethical and practical experience—and systematic data—are less richly available. Nevertheless, taken together, the two national cases are of considerable interest both to the Dutch and Belgians themselves and also to people elsewhere who are considering whether or not to make similar practices legal and, if this is done, how they might most effectively be regulated.

In parts I and II we deal with the legal norms and procedures currently in place in the Netherlands and in Belgium, respectively, and with how these have come to be what they are; we will also critically consider the available evidence bearing on actual practice and on the effectiveness of current law as an instrument of control. Part III consists of contributions on the situation in several other European countries. Part IV consists of some comparative and explanatory reflections stimulated by the material presented earlier in the book.

We have written this book with a reader in mind who is unfamiliar with the Dutch and Belgian situations, and with those in the other countries covered in part III, and has no specific technical knowledge of the law in these countries. We do assume that our reader is interested enough in the problems of public policy surrounding euthanasia to want an account that goes beyond generalisations and

[1] There are a handful of partial exceptions to this generalisation, all of them as far as we are aware concerning assistance with suicide. The most important are the State of Oregon in the United States (see Hillyard & Dombrink 2001), where as the result of a referendum and a recent decision of the United States Supreme Court (*Gonzales v Oregon*, 546 US 243, 2006) physician-assisted suicide is legal, and Switzerland, where assistance with suicide by non-doctors is not illegal and is an institutionalised practice (see ch 16).

superficialities and includes as much as possible of the legal and factual information important for an informed assessment of end-of-life medical practice and its regulation. Our intention has been to present such a reader with reliable information and serious, balanced assessments.

1.2 The Definition of 'Euthanasia' and of Other 'Medical Behaviour that Shortens Life'

'Euthanasia' in the strict and, in the Dutch and Belgian context, the only proper sense refers to the situation in which a doctor ends the life of a person who is suffering 'unbearably' and 'hopelessly' (without prospect of improvement) at the latter's explicit request (usually by administering a lethal injection). When a distinction is made between the two, 'euthanasia' is reserved for killing on request, as opposed to 'assistance with suicide', but generally the two are treated together. We will follow this practice and will often loosely use the single term 'euthanasia' to cover both where the distinction is not relevant.

As we will see in the course of the book, euthanasia in this limited sense is only separated by rather problematic boundaries from related phenomena, such as pain relief in doses known to be likely to hasten the death of the patient, and the withholding or withdrawing of life-prolonging treatment. These other practices are generally considered unproblematic in both Belgium and the Netherlands (as in many other countries), even—perhaps especially—by many vigorous opponents of euthanasia. They are widely regarded in medical law as 'normal medical practice' and thought to give rise to a 'natural death' (that is, one due to the patient's underlying condition). On the whole, they are regarded as quite different from euthanasia and are not thought to require specific control.

There is another sort of behaviour which is also closely related to euthanasia but which—while legal in the Netherlands under narrowly-defined conditions, and known to occur with some regularity in many other countries as well—is everywhere far more controversial than euthanasia: the administration of lethal drugs to shorten the life of persons who cannot or do not explicitly request this (severely defective newborn babies, persons in long-term coma, persons in the final stages of dying).

Together with euthanasia proper, all of the behaviour mentioned above, when engaged in by doctors, is part of a complex of 'medical behaviour that potentially shortens life' (MBPSL). Although there are, of course, important distinctions between different sorts of MBPSL, and some may well be morally and legally more problematic than others, for purposes of legal and ethical analysis, empirical description and effective regulation the whole complex must be considered together.

A terminological note: We use the expression 'shortening of life' when referring to behaviour that a doctor knows is likely to cause the patient to die earlier than he

otherwise would have done. We use the expression 'termination of life' to refer to behaviour of a doctor that is expected to shorten the patient's life *and for which there is no medical indication* (such as to relieve pain or to avoid 'futile' treatment). 'Termination of life' thus includes not only euthanasia (and assistance with suicide), together with termination of life without an explicit request, but also the administration of drugs that are normally used for pain and symptom control in doses that in the circumstances are not medically indicated, and the withholding or withdrawing of life-prolonging treatment that the patient or his representative have not refused and that is not medically futile. These terminological choices are explained in chapter 4.2.3.

1.3 The Legal Status of Medical Behaviour that Terminates Life in the Netherlands and Belgium

Chapters 4 and 9 treat the legal status of euthanasia, physician-assisted suicide, and the other sorts of MBPSL in the Netherlands and in Belgium in detail. To get the reader started, we present here only the bare bones of the legal situation.

In the Netherlands, euthanasia was until 2002 explicitly and apparently absolutely prohibited by two articles of the Dutch Penal Code. Article 293 prohibits killing a person at his request (the offence is a 'qualified' variety of homicide, in the sense that the homicide would otherwise be murder). Article 294 prohibits assisting suicide (suicide itself is not a crime in Dutch law and, but for article 294, assisting suicide would not be either). Despite these apparently unqualified prohibitions, the Supreme Court held in the *Schoonheim* case in 1984[2] that a doctor can rely on the defence of justification due to necessity if he administers euthanatica to a patient who asks him to do so and whose suffering is 'unbearable and hopeless'. In the period preceding and following the *Schoonheim* case the courts, generally following the lead of the Royal Dutch Medical Association, worked out the 'requirements of due care' that must be followed in such a case. As we will see in chapter 4, legislation became effective in 2002 which in effect ratified the solutions arrived at by the courts. A doctor who carries out euthanasia or assists with suicide must first have consulted an independent colleague, who gives a formal opinion as to whether the legal requirements have been met, and he must report what he has done in the context of a special, non-criminal review procedure. Only if he is found to have acted 'not carefully' is the case forwarded to the prosecutorial and medical disciplinary authorities.

What has been said of euthanasia does not apply to situations in which a doctor administers lethal drugs without the patient having made an explicit request, although here, too, the general contours of the emerging legal norms are becoming

[2] Supreme Court, 27 November 1984, *Nederlands Jurisprudentie* 1985, no 106. An English translation can be found in GB&W: 322*ff.*

clear. In the case of severely defective newborn babies (and probably of coma patients), recent legal developments seem, as we will see in chapter 6, to point the way to a generally acceptable outcome, but these matters remain far more controversial than euthanasia proper.

In Belgium, euthanasia (but probably not physician-assisted suicide) was illegal until 2002, when legislation was passed legalising it along lines generally similar to those in the Netherlands. Before that time, it undoubtedly took place in actual medical practice, but there had never been a prosecution or court decision in which the possibility of a legal justification could be tested. The same still applies to termination of life without a request from the patient.

1.4 Reactions from Abroad to the Dutch and Belgian Situation

Dutch society has over the centuries attracted considerable foreign attention. Admiration for Dutch achievements in commerce, social organisation, science, the arts and engineering (especially water control and land reclamation) has been mixed with scepticism, disapproval, and dismay, especially at Dutch 'toleration' (of unorthodox religion, illegal drug use, novel sexual relations and so forth). But foreign characterisations of Dutch society, favourable or unfavourable, often tell us more about the situation in the observer's own country than they do about the Netherlands.[3] Thus what the German traveller in the 17th century who was shocked at the fact that 'servant girls in Holland behaved and dressed so much like their mistresses that it was hard to tell which was which,'[4] principally tells us is that social differences were expected to be highly visible in contemporary Germany.

Of no current subject is this more true than it is of euthanasia. Although the Dutch experience with euthanasia has attracted a great deal of comment, until recently little of this went much beyond expressions of enthusiastic welcome or of moral outrage to consider what is actually happening in the Netherlands. The Dutch experience has mostly been seen by foreign observers as a source of ammunition to be used for domestic purposes. Those who are inclined to react to Dutch and, more recently, Belgian developments in this polemical way are invited in the course of this book to consider the complexities of the legal, moral and empirical questions involved. On close examination, none of these seem to lend themselves to simple, absolute answers.

The criticisms from abroad do raise some fundamental questions, in particular with regard to the problem of adequate legal control. Unfortunately, on the whole, such concerns were in the past often voiced in a way which did not invite serious

[3] Compare Van Ginkel 1997: 15–42.
[4] Israel 1995: 2.

response. Imprecision, exaggeration, suggestion and innuendo, misinterpretation and misrepresentation, ideological *ipse dixitism*, and downright lying and slander, took the place of careful analysis of the problem and consideration of the Dutch evidence. It is perhaps understandable that the Dutch reaction tended to be dismissive, since such critics did not seem to deserve attention and keeping up with their misrepresentations would have been a full-time job.

The previous paragraph is how, almost 10 years ago, we characterised the situation in the international debate.[5] Since then the whole subject seems to have become normalised and the general tone of the professional literature is less hostile and more respectful, if not necessarily less critical. The serious press, too, is prepared to investigate Dutch and Belgian developments carefully and report on them in a reasonably objective way. Thus, when the 'Groningen protocol' dealing with termination of life in neonatology was suddenly and briefly international news—the Vatican newspaper *Osservatore Romano* having compared the doctor most prominently involved to the Nazi doctors—responsible newspapers like the *New York Times* and the *Guardian* had experienced reporters do careful and accurate articles about what was really going on.[6]

The more relaxed atmosphere that now prevails is all to the good. Other countries may, like Belgium, choose to follow the Dutch lead, or they may decide to deal with the enormous problems arising from the medicalisation of death in modern health care systems in some other way. In either case, the relevance of the Dutch and Belgian experience to efforts elsewhere to deal with the problems of achieving adequate control over behaviour of doctors that affects the manner and the timing of death, can only be properly discussed after one appreciates, in detail, what Dutch and Belgian euthanasia practice entails and how the legal norms and enforcement processes that regulate it are working in practice.

1.5 Four Theoretical Themes

Our first objective, as we have noted, is to give as full and as accurate a description as we can of the law on euthanasia and other medical practices that potentially shorten life, of actual medical practice, and of the functioning of the control system, and to analyse the meaning of all this material for various questions in the international public debate. We focus in particular on the Netherlands and Belgium, but we approach the matter in a comparative spirit, and in part III there are country reports on a number of other Western European countries.

But we would not be true academics if we were prepared to leave it at that. In fact, we have a number of more 'theoretical' interests to which we hope this book will also make a contribution. We will return to these at various points in the book

[5] GB&W: 20–21.
[6] See ch 6, n 1.

The approach we take to comparison is *functional*, by which we mean that it seems to us to make little sense to study the regulation of euthanasia by focusing just on the rules concerned. In describing the legal regulation of euthanasia in the Netherlands and Belgium (chapters 4 and 9) and in the countries treated more briefly in part III, our point of departure is not the rules themselves but the behaviour (mostly of doctors) that they regulate.[13] We begin with an exploration of the whole range of 'medical behaviour that potentially shortens life' (MBPSL) in order to locate 'euthanasia' in the context of other sorts of medical behaviour with which it shares important features and from which it cannot always easily be distinguished, either analytically or in practice. The questions we address are these: what, if any, rules are applied to medical behaviour that potentially shortens life? and how and why is 'euthanasia' separated out for special treatment?

The approach we take to comparison is also *non-formalistic*. We do not have to take a position on the question whether such an approach would be necessary in every area of law, but in studying the law concerning euthanasia and the other MBPSL, even in one country but certainly when one engages in comparison, it is essential to take the concept of 'law' in a broad sense. As it regulates everyday medical practice, and in particular as it develops and changes, the law consists of much more than formal 'legal' texts such as statutes or judicial decisions. These are preceded by, surrounded by, and followed by a vast amount of 'para-legal' sources of law. It would, in every country we know of, be impossible to state what the law 'is', let alone what it will be tomorrow, without taking account—to name a few of the most obvious and important other sources of law—of parliamentary reports (such as that of the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill), of reports of official advisory committees (such as those of the French National Ethics Committee), of reports and guidelines of official organs of the medical profession, and so forth.

It is also important to compare the rules concerning euthanasia and other MBPSL in a *multilayered* way. The rules themselves are the first layer, and we will pay careful and detailed attention to them. But rules are always *embedded* in an historical, institutional, political, cultural and social environment, without which their meaning cannot be understood. The second and third layers of comparison, in our case, concern specifically the (organisation of the) health care system within which the rules are situated, and more generally the political culture and constitutional background of the legal system of which they are a part. In effect, we are thus engaged in comparative institutional and political sociology.

Finally, in making comparisons we do so from the point of view of the *social working* of legal rules.[14] This book is not the place to go into the theoretical difficulties of a simplistic instrumentalist approach to the 'effectiveness' of law, one

[13] Compare the approach to comparative law developed by Kagan (Kagan 1990; Kagan & Axelrad 2000; Gunningham, Kagan & Thornton 2003). We use 'rules' in this context as shorthand, referring to the varying mix of rules and principles characteristic of law (*cf* Braithwaite 2002).

[14] See Griffiths 2003.

that treats legal rules as direct (potential) causes of behaviour. But looking at the place that euthanasia law plays in the social practice of euthanasia does afford a wonderful opportunity to consider how complex the relationship between rules and behaviour can be, and we will be engaged in doing so at many points in this book.

From the perspective of the idea of the social working of legal rules, it is obvious that in studying euthanasia law comparatively it is not enough to look at what the rules are and how they came to be that way, it is also essential to take account of what happens to them on the 'shop floor' of everyday life. How and when do people use the rules? Do the rules make a difference in social interaction? What difference? How does this come about? Because the 'social working' approach assumes that the social meaning of a legal rule lies not in legal texts but in the difference the rule ultimately makes in social life, in engaging in comparative law in the way we seek to do, we are also necessarily engaged in comparative sociology of law.[15]

[15] Our approach to comparative law owes much to the writings of Twining (eg 2000, forthcoming). We take comparative law to be a *descriptive* discipline, subservient to efforts to explain difference and change in law. Its task is to enable us to describe (some aspect of) law in a way which permits answers to the questions, whether there are differences in time or place and precisely what they are.